



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.caresource.com/just4me or by calling 1-888-815-6446.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$6,600 Individual / \$13,200 Family per Benefit Year.	You must pay all the costs up to the Deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the Deductible .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$6,600 Individual / \$13,200 Family	The Out-of-Pocket Limit is the most you could pay during a coverage period for your share of the cost of covered services. Copayments and coinsurance are applied toward the out-of-pocket limit. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premium, balance-billed charges and health care services that are not covered by this plan.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes how the plan and you will pay for <i>specific</i> covered services.
Does this plan use a <u>network of providers</u> ?	Yes. For a list of network providers, see	If you use an in-network doctor or other health care Provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use

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CareSource Just4Me Healthcare with Heart (Catastrophic)

Coverage Period: 01/01/15 – 12/31/15

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual | Plan Type: HMO

	www.caresource.com/just4me or call 1-888-815-6446.]	an out-of-network Provider for some services. Plans use the term in-network, Preferred or participating for Providers in their network. See the chart starting below for how this plan pays different kinds of Providers .
Do I need a referral to see a specialist?	No.	You can see the Network Specialist you choose without permission from the plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about Excluded Services

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$0 after Deductible	Not covered.	
	Specialist visit	\$0 after Deductible	Not covered.	
	Other practitioner /chiropractic office visit	\$0 after Deductible	Not covered.	Manipulation therapy limited to 12 visits per Benefit Year.

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If you have a test	Preventive care/screening/immunization	No charge	Not covered.	Services must meet requirements as determined by federal and state law.
	Diagnostic test (x-ray, blood work)	\$0 after Deductible	Not covered	
	Imaging (CT/PET scans, MRIs)	\$0 after Deductible	Not covered.	Prior Authorization Required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caresource.com/just4me	Preventive drugs	\$0 after Deductible	Not covered.	Retail: up to a 31-day supply.
	Generic drugs	\$0 after Deductible	Not covered.	Mail-Order: up to a 90-day supply.
	Preferred brand drugs	\$0 after Deductible	Not covered.	Certain drugs may require a prior authorization.
	Non-preferred brand drugs	\$0 after Deductible	Not covered.	You may be required to use a lower cost drug(s) prior to benefits under your policy being available for certain prescribed drugs

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	Specialty drugs	\$0 after Deductible	Not covered.	\$0 maximum Coinsurance.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$0 after Deductible	Not covered.	Prior Authorization Required.
	Physician/surgeon fees	\$0 after Deductible	Not covered.	
If you need immediate medical attention	Emergency Room Services	\$0 after Deductible	\$0 after Deductible	
	Emergency medical transportation	\$0 after Deductible	\$0 after Deductible	Prior Authorization required for air or water transportation or non-emergency health services.
	Urgent care	\$0 after Deductible	\$0 after Deductible	If you receive services in addition to urgent care, additional copays, deductibles, or coinsurance may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$0 after Deductible	Not covered.	Prior Authorization Required.
	Physician/surgeon fee	\$0 after Deductible	Not covered.	None

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If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$0 after Deductible	Not covered.	Prior Authorization required for all inpatient stays, partial hospitalization programs and intensive outpatient services.
	Mental/Behavioral health inpatient services	\$0 after Deductible	Not covered.	
	Substance use disorder outpatient services	\$0 after Deductible	Not covered.	
	Substance use disorder inpatient services	\$0 after Deductible	Not covered.	

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If you are pregnant	Prenatal and postnatal care	\$0 after Deductible	Not covered.	Covers initial physician visit and all subsequent prenatal visits, postnatal visits, and physician delivery charges covered under the Global maternity fee. Your cost for inpatient services only. See above for physician delivery charges
	Delivery and all inpatient services	\$0 after Deductible	Not covered.	Your cost for inpatient services only. See above for physician delivery charges.

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If you need help recovering or have other special health needs	Home health care	\$0 after Deductible	Not covered.	Limited to one hundred (100) combined visits per benefit year.
	Rehabilitation services	\$0 after Deductible	Not covered.	Twenty (20) visit limit applies to each of physical therapy, occupational therapy, speech therapy and pulmonary rehab. Thirty-six (36) visit limit for cardiac rehab. Twelve (12) visit limit for spinal manipulation. Home health care limits apply when services are rendered in the home.
	Habilitation services	\$0 after Deductible	Not covered.	Habilitation services are subject to the visit limits described in “Rehabilitation Services,” which is a combined limit for Habilitation and Rehabilitation services.
	Skilled nursing care	\$0 after Deductible	Not covered.	Any combination of benefits for skilled nursing facility/inpatient rehabilitation facility services is limited to 90 days per calendar year.
	Durable medical equipment	\$0 after Deductible	Not covered.	May require prior authorization.
	Hospice service	No charge.	No charge	Prior Authorization required. This benefit is not subject to deductible.
If your child needs dental or eye care	Eye exam	No charge	Not covered.	Limit of one routine eye exam per benefit year.
	Glasses	No charge	Not covered.	Limited to 1 pair per benefit year and 1 replacement pair if medically necessary.

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	Dental check-up	Not covered.	Not covered.	No coverage for dental check-up.
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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Hearing aids for adults
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs.

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Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic Care
- Infertility treatment

Your Rights to Continue Coverage:

Federal and state laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-888-815-6446. You may also contact your state insurance department at 1-800-595-6053.

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Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact 1-800-595-6053.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is
not a cost
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers: \$7,540**
- **Plan pays: \$940**
- **Patient pays: \$6,600**

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$6,600
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$0
Total	\$6,600

Managing type 2 diabetes

(routine maintenance of
a well-controlled condition)

- **Amount owed to providers: \$5,400**
- **Plan pays: \$0**
- **Patient pays: \$5,400**

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$5,400
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$0
Total	\$5,400

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**,

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and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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